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Presentation to:

Senate Public Health and Welfare Committee

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Presented by:
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Good afternoon and thank you Madame Chair and members of the committee for this opportunity to present and explain the work that the Kansas Foundation for Medical Care (KFMC) performs on behalf of beneficiaries across the State of Kansas. My name is Kenneth Mishler and I am the President and CEO of KFMC.

In 1972, KFMC was formed by the Kansas Medical Society to provide a mechanism for physician peer review at a time when more and more third party payers were making claim determinations regarding utilization and quality that impacted payment decisions. KFMC provided a mechanism for physicians to begin evaluating each other's work against established standards, both professional and community.

Since 1972, the federal requirements for KFMC's work have undergone a number of transformations. From Professional Standards Review Organizations (PSROs) to Professional Review Organizations (PROs), both of which reviewed provider activities retrospectively. This structure attempted to influence practice behaviors by reviewing what had happened in the past in an effort to improve care delivery in the future.

In 1992, the work the KFMC conducted on behalf of the Federal Government began to change from primarily retrospective review to introducing the evaluation of community-wide practice patterns and educational feedback to the provider community. Since 2001, KFMC has been the federally designated Quality Improvement Organization for the State of Kansas, which works with providers proactively to implement processes that incorporate and hard-wire quality into the delivery of healthcare service.

KFMC employs a variety of health care professional with expertise in quality improvement, including physicians, nurses, coding and review specialists and pharmacists. Additionally, KFMC has many years of comprehensive data analytic experience, helping contractors gather and analyze healthcare information. KFMC has the capability to conduct analyses on robust data sets including Medicare and Medicaid claims data. Not only can we access and record data, more importantly we present data in meaningful, useful reports that center on service, outcomes and client satisfaction.

KFMC is a 501(c)6 not-for-profit organization that is governed by a diverse, eleven member Board of Trustees that represents the customers we serve. Our board is made up of no more than five physicians, with the remainder of members being selected from a variety of professionals representing nursing, hospitals, long-term care, business and beneficiaries. A copy of our current board in included in your packet.

KFMC is committed to carrying out our mission of "**Leading innovation to improve the quality, effectiveness and safety of healthcare"** in every activity we pursue.

KFMC's work with the Centers for Medicare and Medicaid Service (CMS) is conducted in three year contracts and in our current work it is divided into four major themes. In this work KFMC not only works with individual providers, we also convene statewide learning and action networks that bring together providers to share and spread improvement experiences. The four major themes of our current work are:

- **<u>Beneficiary and Family Center Care</u>** –

- KFMC listens to and responds to concerns and complaints of Medicare beneficiaries and families
- If a complaint review confirms a quality problem, KFMC will work with the provider to identify opportunities to modify and improve their processes for delivering quality care.
- KFMC will also take the role of mediator to help resolve problems between beneficiaries and providers.

- **Improving Individual Patient Care** – This work involves working with care providers to implement evidence based practices to reduce central intravenous line associated blood stream infections, catheter associated urinary tract infections, surgical site infections and to reduce the incidence of *Clostridium difficile* or C diff infections.

  KFMC has worked with the long-term care community and their respective trade associations to reduce the incidence of pressure ulcers (bed sores) and the use of physical restraints. Because of the involvement of the providers, stakeholders, communities and the QIO working together toward a common goal, Kansas long-term care residents have one of the lowest incidences of these complications in the country.

  KFMC is also participating in a national program to reduce the incidence of medication adverse events in high risk patients with multiple disease states and taking multiple medications. KFMC will bring together clinical pharmacists, primary care clinics and other providers that care for older patients to reduce the risk of potentially negative consequences of polypharmacy and to improve medication management of anticoagulation, diabetes and the use of antipsychotics in the older population.

- **Improving Health for Populations and Communities** – Electronic health records provide physicians with a powerful tool to improve care, prevent errors, measure performance and share information with patients and other providers. KFMC is working with the physician community to help them use their EHRs to impact patient care by:
  - Improving their rates of colorectal cancer screening and mammography
  - Improved administration of influenza and pneumococcal vaccines
  - Reducing cardiac risk factors that include a focus on treatment of hypertension to goal, smoking cessation, high cholesterol and increasing heart healthy behaviors.

  More emphasis is being placed on physicians to report quality related data. KFMC is working with physicians to utilize their EHRs to participate in the CMS Physician Quality Reporting System. KFMC is providing technical assistance to providers to accurately capture and report this data directly from their EHRs. This will also be a source of data for the CMS Physician Compare Website.

- **Integrating Care for Populations and Communities** – Within 30 days of discharge, 17.6% of Medicare beneficiaries are re-hospitalized and it is believed that up to 75% of these admissions can be avoided. KFMC is facilitating activities in four separate communities in Kansas to focus efforts to reduce avoidable hospital readmissions. Transitioning through the various levels of care is a complex process and KFMC is working with these

communities to find new ways to work together and to implement evidence based practices with the goal of reducing avoidable hospitalizations by 20% over 3 years.

In your packet you will find an abstract of an article published just last week in the Journal of the American Medical Association. This article details the efforts of the QIO community in a care transitions pilot program conducted in our last contract. Communities that worked with their state's QIO reduced the incidence of hospital readmissions double that of equally matched communities that did not work with their QIO.

External Quality Review Organization - The Federal Government requires states to engage the services of an External Quality Review Organization (EQRO) when they implement Medicaid managed care. KFMC has served as the EQRO for Kansas since 1995. Being the QIO in Kansas helps provide KFMC the knowledge and experience required to be an EQRO.

The role of the EQRO is to review the access, quality and timeliness of health care services received by Medicaid and Children's Health Insurance Program beneficiaries. The EQRO follows CMS external quality review protocols when conducting its review activities; 75% of the costs for these activities are paid by the Federal Government. As the EQRO, KFMC evaluates the MCOs' compliance with Federal regulations through compliance audits. KFMC also evaluates the accuracy of MCO reported performance measurement data and performance improvement outcomes. In efforts to improve the quality of care delivered, KFMC provides technical assistance to the MCOs and the State regarding development and evaluation of methodologies for measurement and improvement projects, including intervention selection. Historically, KFMC has also conducted a number of studies and surveys for the State identifying trends and opportunities for improvement.

Further details of the services KFMC has the ability to provide to the State are included in your packet. Currently KFMC has contracts with the KDHE, Division of Health Care Finance for Medicaid Managed Care and with the Kansas Department for Aging and Disability Services for review of Mental Health and Addiction and Prevention Services, as well as two Home and Community Based Service waivers.

Utilization Review Services - Since 1982, KFMC has provided utilization review services for the Kansas Medicaid non-managed care population. KFMC utilizes standardized guidelines and reviews selected sample cases for accuracy related to diagnosis, quality, procedure validation, medical necessity, discharge appropriateness and appropriateness of health care provided to the Medicaid consumer. If there is any question related to these review elements, KFMC engages the services of another Kansas physician, through a well-developed network of peer reviewers across the state, to assist in this review process.

With the expansion of managed care in Kansas, this contract is due to expire on June 30, 2013. However, KFMC will continue to provide these services for private review contracts that we hold with hospitals and health systems located both in and outside of Kansas.

KFMC Regional Extension Center – In 2010, KFMC applied for and was awarded the designation as the Regional Extension Center for Health Information Technology for the State of Kansas by the Health and Human Services Office of the National Coordinator. This program is modeled

after the successful agriculture extension centers that assist farmers to implement new techniques for growing crops and natural resource management. In a similar sense, KFMC supports physician and mid-level providers with direct, individualized technical assistance in adoption and meaningful use of Electronic Health Records.

The role of the Regional Extension Center is to provide on-site assistance to primary care practices of less than 10 providers in:

- Selecting a certified EHR
- Achieving effective implementation of that EHR
- Enhancing clinical and administrative workflows to optimally leverage an HER's potential to improve quality and value of care, including patient experience as well as outcome of care
- Observing and complying with applicable legal, regulatory, professional and ethical requirements to protect the integrity, privacy and security of patient's health information.

One year into this program, the Regional Extension Centers expanded this work to provide similar assistance to critical access hospitals. KFMC has partnered with the Kansas Hospital Education and Research Foundation to meet the unique needs of this provider population as they strive to implement electronic health records in their organizations.

There is a map in your packet that identifies the location of the nearly 1500 providers we are assisting in this endeavor.

Additional work in which KFMC participates in with the State of Kansas:

- External review organization for the Kansas Insurance Department. In this capacity we conduct independent external review of adverse decisions and render opinions in accordance with State Statutes and regulations.
- In KDHE's Office of Local and Rural Health KFMC works with providers as a part of the HRSA Rural Hospital Flexibility Program (FLEX Program). Over the next year KFMC will work with 28 critical access hospitals across the state on quality measure reporting and improvement in the areas of pneumonia and heart failure treatment, emergency department transition, and immunizations. We work with these hospitals to make the reporting and improvement of measures a part of their routine practices.
- Finally, KFMC is working with the KDHE's Kansas Immunization Program, providing project management, survey and analysis services for a Centers for Disease Control and Prevention grant.

Once again I appreciate this Committees' attention and this opportunity to share some of the work KFMC conducts on behalf of the Federal and State Governments. It will be my pleasure to answer any questions.

Medicare Quality Improvement Organizations

Who

Quality Improvement Organizations (QIOs) work with consumers, physicians, hospitals, nursing homes, and home health agencies to improve the effectiveness, efficiency, economy, and quality of services in order to make sure that patients get the right care at the right time.

QIOs also investigate beneficiary complaints about quality of care and use the complaints as a basis for improving the way health care is delivered by individual providers and the health care system overall.

"In their role as health care leaders, QIOs are integral to Medicare's efforts to preserve the Trust Fund for future generations. QIOs take the most cutting-edge, proven methods out to providers and help them deliver care that has greater value and quality for patients. They work at the local level, but they make a national impact. QIOs are the premier 'go-to' resource with the clinical training, the quality improvement expertise, and the passion to drive health care innovation. QIO staff and CMS look forward to continuing work with providers, partners, and consumers to reach greater heights in health care quality in the coming years."

Barry M. Straube, M.D.
CMS Chief Medical Officer
Director, Office of Clinical Standards and Quality

For more information on the QIO Program, please visit www.qualitynet.org/medqic.

Where

Under the direction of the Centers for Medicare & Medicaid Services (CMS), the QIO Program consists of a national network of 53 QIOs located in each of the 50 U.S. states, the District of Columbia, Puerto Rico, and the Virgin Islands.

Why

QIOs work with providers and practitioners at the local level as part of CMS' commitment to ensure consistent, high-quality health care for Medicare beneficiaries across the country.

How

QIO work builds on a growing evidence base about how to improve the quality and efficiency of the health care sector. QIOs focus on the following priorities:

1. Protecting the rights of beneficiaries who are concerned about the quality of their care;
2. Improving the safety of care in America's nursing homes and hospitals as part of the National Patient Safety Initiative;
3. Increasing the use of screenings for breast and colon cancer and vaccinations for flu and pneumonia by leveraging innovations in health information technology;
4. Reducing gaps in the quality of care for minority patients with diabetes by empowering patients to control their disease through self-management training;
5. Slowing the progression of kidney disease to kidney failure; and
6. Coordinating care across all types of providers, settings, and levels to ensure better patient outcomes and greater system-wide efficiency.

This material was prepared by Qualis Health, the Quality Improvement Organization Support Center for Communications, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. CommQ-08-10

Quality Improvement Organizations
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Kansas Foundation for Medical Care, Inc.

QIO Program
Beneficiary and Family Centered Care

Making Care More Patient-Centered
Health care is personal. Every individual's experience with the health care system is different—influenced by preferences and values, family situation, cultural traditions, and lifestyle. Because these factors strongly affect health outcomes, patient-centered care is increasingly a top priority in every health care setting.

The Quality Improvement Organization (QIO) Program is an ally in this effort. From August 2011 through July 2014, Medicare beneficiaries, caregivers, and health care providers are encouraged to join in local and national initiatives to increase patient and family engagement. Beneficiaries and families also will have the opportunity to contribute to local QIO improvement initiatives.

A Major Force for Improvement
QIOs in every state and territory, united in a network administered by the Centers for Medicare & Medicaid Services (CMS), have the flexibility to respond to local needs. At the same time, they offer patients and providers the opportunity to contribute to broader health quality goals, such as those set by the U.S. Department of Health & Human Services' National Quality Strategy. Current QIO Program initiatives are supported by a wide range of national and local partners that include major health advocacy organizations and agencies that work with older Americans.

Empowering Beneficiaries and Families
Some of the QIO Program's newest beneficiary and family centered initiatives include:

Increased dialogue with Medicare beneficiaries. QIOs have expanded opportunities for listening to and addressing beneficiary and family concerns, and are using the information they gather to improve Medicare's entire system of health care. For example, when complaint review confirms a quality problem, QIOs work with the provider to identify opportunities to modify and improve their processes for delivering quality care.

QIO Program Patient and Family Engagement Campaign. Beginning in August 2012, local QIOs will offer tools and strategies that equip health care providers to engage patients and families, as well as provide self-advocacy information to Medicare beneficiaries and caregivers. Every state and territory will participate in the campaign, which is part of CMS' national commitment to patient-centered care.

Continued

The QIO Program is an integral part of the U.S. Department of Health and Human Services' National Quality Strategy and is the largest federal program dedicated to improving health quality at the community level. As a major force and trustworthy partner for the continual improvement of health and health care for all Americans, QIOs work with patients, providers and practitioners across organizational, cultural and geographic boundaries to spread rapid, large-scale change. The work that QIOs perform spans every setting in which health care is delivered, even the critical transitions between those settings. The Program focuses on three aims: better patient care, better individual and population health and lower health care costs through improvement.

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QIO Program
Beneficiary and Family Centered Care

Leading Rapid, Large-Scale Change in Health Quality

People with Medicare have the right to quality health care. In addition to addressing beneficiary and family concerns, QIOs work to remove the socioeconomic, educational and cultural barriers that can prevent access to health care. They also bring together health care providers and community stakeholders for rapid learning and action that improves patient care, improves the health of populations and communities and lowers health care costs through improvement.

Current QIO Program priorities include:

Improving Individual Patient Care. KFMC improvement initiatives with nursing homes initially target pressure ulcers and physical restraints, then evolve to address other health care-acquired conditions, such as falls and catheter-associated urinary tract infections. To decrease adverse drug events, KFMC is bringing clinical pharmacists, physicians and primary care clinics together in local collaboratives to improve care coordination for patients who take multiple medications. With hospitals, KFMC is focusing resources on reducing health care-associated infections.

Improving Health for Populations and Communities. KFMC is helping physicians collect and use data from electronic health records to measure and improve their clinical performance, including the rates of preventive services they provide. In addition, KFMC links communities to the "Million Hearts Campaign." This joint initiative of CMS, the American Heart Association, and other health care stakeholders aims to reduce cardiac risk factors that include hypertension, smoking and high cholesterol.

Integrating Care for Populations and Communities. KFMC is bringing together hospitals, nursing homes, patient advocacy organizations, agencies that serve seniors and other stakeholders in community coalitions to reduce avoidable hospital readmissions. While improvement strategies include improving the hospital discharge planning process, they also incorporate a strong emphasis on activating patients to play a greater role in managing their own health.

Learn more and become involved

KFMC invites all beneficiaries, caregivers and health care providers to be part of its new improvement initiatives. To express an interest, contact KFMC or visit *kfmc.org.*

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QIO Program
Integrating Care for Populations and Communities

Improving Transitions of Care

Avoidable readmissions place a physical and emotional burden on patients and families, cost Medicare an estimated $12 billion annually and soon will create a financial liability for hospitals that accept Medicare reimbursement—while interventions for improving care transitions are both known and effective. The 14 communities nationwide that participated in a recent Quality Improvement Organization (QIO) Program initiative, for example, reduced admissions per 1,000 beneficiaries by 5.6 percent, compared to a 3.4 percent reduction in 52 peer communities.

As a result, health care providers and patient advocates across the country are focusing increased attention on improving transitions of care for every patient. The QIO Program is an ally in this effort. All hospitals and other provider settings should be encouraged to take advantage of QIO assistance from August 2011 through July 2014 to build a multistakeholder coalition, identify the root causes of readmissions, select an intervention and put it into action.

A Major Force for Improvement

QIOs in every state and territory, united in a network administered by the Centers for Medicare & Medicaid Services (CMS), have the flexibility to respond to local needs. At the same time, they offer providers the opportunity to contribute to broader health quality goals, such as those set by the U.S. Department of Health & Human Services' National Quality Strategy.

Current QIO Program initiatives are aligned with other major health quality improvement programs and can help providers improve the quality of care for Medicare beneficiaries who transition among care settings. In addition, by working with their local QIO, community care transitions coalitions may qualify for federal funding to continue their efforts.

New Ways to Work Together

The latest in improvement science, including new models for accelerating and spreading change, has shaped the QIO Program's approach. This means providers have more and different ways to be a part of QIO initiatives. QIOs are functioning differently, too. Rather than limiting their role to technical assistance, they are convening statewide learning and action networks (LANs) that recognize everyone has knowledge that can contribute to better care. By participating in a LAN, health care providers can harness the power of a 24/7 community for addressing common challenges, connect with a peer facility for mentoring, and be the first to know about improvement breakthroughs–and how they can replicate them in their own facility or practice.

Bold Goals for Better Care

Within 30 days of discharge, 17.6 percent of Medicare beneficiaries are re-hospitalized, and up to 76 percent of these readmissions may be preventable. Of beneficiaries who are readmitted within 30 days, 64 percent receive no post-acute care between discharge and readmission.

Continued

The QIO Program is an integral part of the U.S. Department of Health and Human Services' National Quality Strategy and is the largest federal program dedicated to improving health quality at the community level. As a major force and trustworthy partner for the continual improvement of health and health care for all Americans, QIOs work with patients, providers and practitioners across organizational, cultural and geographic boundaries to spread rapid, large-scale change. The work that QIOs perform spans every setting in which health care is delivered, even the critical transitions between those settings. The Program focuses on three aims: better patient care, better individual and population health and lower health care costs through improvement.

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QIO Program
Integrating Care for Populations and Communities

Communities that join the QIO Program's initiative to integrate care for populations and communities will contribute to a three-year, 20 percent national reduction in readmissions within 30 days of hospital discharge. Participants can expect to benefit from membership in a KFMC transitions coalition comprised of hospitals, nursing homes, home health agencies, dialysis centers, hospices and palliative care facilities, senior advocates like area agencies on aging and other local stakeholders. QIOs in every state and territory will convene these coalitions and provide technical support as they implement a comprehensive, fully integrated approach to reducing avoidable readmissions. Other benefits of participation include:

Evidence-Based Interventions. Each community will select one or more interventions from a set of multidimensional programs for improving care transitions whose effectiveness has been documented in the scientific and medical literature. These include the: Care Transitions Intervention℠ (Eric Coleman), Transitional Care Model (Mary Naylor), Better Outcomes for Older Adults through Safe Transitions or "BOOST" (Society of Hospital Medicine), Best Practices Intervention Package for Transitional Care Coordination (Home Health Quality Improvement Initiative), Interventions to Reduce Acute Care Transfers or "INTERACT" (Florida Atlantic University), STate Action on Avoidable Rehospitalizations or "STAAR" (Institute for Healthcare Improvement), Re-engineered Discharge or "Project RED" (Boston University), Geriatric Resources for Assessment and Care of Elders or "GRACE Team Care Model" (Indiana University), and the Bridge Model of Transitional Care (Illinois Transitional Care Consortium).

Support for Sustainability. To rapidly increase capacity for improving care transitions, QIOs are focusing their work on communities with high readmission rates that are not already supported by federal funding (such as the Administration on Aging's Aging and Disability Resource Center program and CMS' Community Based Care Transitions demonstration). QIOs will assist participating communities to build the structure and experience they need to qualify for funding through Section 3026 of the Affordable Care Act.

Learn more and become involved

KFMC invites all providers, community stakeholders, beneficiaries, family members and caregivers to become partners in its new improvement initiatives. More information regarding KFMC's Integrating Care for Populations and Communities initiative is available at *kfmc.org*. To express an interest, contact KFMC or visit *kfmc.org*.

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QIO Program
Improving Health for Populations and Communities

Better Primary Prevention and Diagnosis
Electronic health records (EHRs) give physicians a powerful tool for preventing errors, measuring performance and sharing information with patients and other providers. As more practitioners adopt EHRs and make them part of the patient care process, they also are relying on them to coordinate individual care and manage population health.

The Quality Improvement Organization (QIO) Program is an ally in this effort. From August 2011 through July 2014, physician practices are encouraged to take advantage of QIO assistance with clinical data reporting and to join in local improvement initiatives that leverage EHR functionality to increase rates of preventive services and decrease cardiac risk factors.

A Major Force for Improvement
QIOs in every state and territory, united in a network administered by the Centers for Medicare & Medicaid Services (CMS), have the flexibility to respond to local needs. At the same time, they offer providers the opportunity to contribute to broader health quality goals, such as those set by the U.S. Department of Health & Human Services' National Quality Strategy and its Action Plan for Reducing Health Care-Associated Infections.

Current QIO Program initiatives are aligned with other major health quality improvement programs and can help physician practices improve their ability to report clinical quality data from their EHR systems and prepare for value-based payment by Medicare and other insurers.

New Ways to Work Together
The latest in improvement science, including new models for accelerating and spreading change, has shaped the QIO Program's approach. This means providers have more and different ways to be a part of QIO initiatives. QIOs are functioning differently, too. Rather than limiting their role to technical assistance, they are convening statewide learning and action networks (LANs) that recognize everyone has knowledge that can contribute to better care. By participating in a LAN, health care providers can harness the power of a 24/7 community for addressing common challenges, connect with a peer facility for mentoring, and be the first to know about improvement breakthroughs—and how they can replicate them in their own facility or practice.

Harnessing Health IT for Better Care
Current QIO Program initiatives for improving population and community health through effective use of health information technology include:

Increasing rates of preventive screenings. Effective use of health information technology increases the capacity of primary care physicians to deliver preventive services. Building on the success of their previous EHR initiatives, QIOs are working with primary care practices that want to take full advantage of their EHR's functionality for supporting care coordination to increase rates of screening mammograms, colorectal screenings and influenza and

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pneumonia vaccinations. Participating practices can increase the number of patients for whom they have complete preventive care data, identify patients who need preventive care, measure and improve preventive care performance and report data to CMS.

Reducing cardiac risk factors. The QIO Program is a partner in the "Million Hearts" campaign, a joint initiative of CMS, the American Heart Association and other national health care stakeholders that aims to improve America's heart health. "Million Hearts" seeks to reduce cardiac risk factors that include hypertension, smoking and high cholesterol and increase heart-healthy behaviors, such as aspirin for those who need it. Through KFMC, local physicians and patients can link to resources for care coordination and patient self-management. KFMCs also supports practices in using their EHRs to coordinate care and measure improvement in the health of patients who are most at risk for a heart attack.

Supporting more and better clinical quality data. Until recently, physician practices that wanted to participate in the CMS Physician Quality Reporting System (PQRS) had to submit claims or registry data. Now practices can report these data directly from their EHR systems. KFMC is providing technical assistance to accurately capture the required data elements and extract them for reporting. This qualifies practices for incentive payments that add to their usual annual Medicare reimbursement amounts. It also generates information for CMS' Physician Compare website, which will help consumers use information about quality to select a health care provider.

Connecting EHRs to quality improvement. KFMC coordinates with the Kansas regional extension center (REC) to offer improvement expertise to practices that have implemented an EHR but not yet attained meaningful use. This may include, for example, offering assistance in interpreting clinical performance data and using it to drive and measure change. QIOs also are encouraging participation in CMS' EHR incentive programs.

Learn more and become involved

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QIO Program
Improving Individual Patient Care

Making Care Safer

There is no longer any question: adopting safer processes for delivering health care can save lives and lower costs. As a result, hospitals, nursing homes, physicians and pharmacists across the country are focusing increased attention on improving safety for every patient.

The Quality Improvement Organization (QIO) Program is an ally in this effort. From August 2011 through July 2014, health care providers and stakeholders are encouraged to join in local improvement initiatives that target three high prevalence, high cost clinical topics: hospital acquired infections, such as central line associated bloodstream infections; health care associated conditions in nursing homes, including pressure ulcers; and adverse drug events, like those that may result when older people take multiple medications.

A Major Force for Improvement

QIOs in every state and territory, united in a network administered by the Centers for Medicare & Medicaid Services (CMS), have the flexibility to respond to local needs. At the same time, they offer providers the opportunity to contribute to broader health quality goals, such as those set by the US Department of Health & Human Services' National Quality Strategy and its Action Plan for Reducing Health Care-Associated Infections.

Current QIO Program initiatives are aligned with other major health quality improvement programs and can help providers prepare for value-based purchasing, meet their commitment to the Partnership for Patients and comply with certain accreditation or licensure requirements.

New Ways to Work Together

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Bold Goals for Better Care

Health Care-Associated Infections in Hospitals

Hospitals that join KFMC's health care-associated infection (HAI) initiatives will contribute to as much as a 50 percent reduction in national HAI rates. The initiative will reduce catheter-associated urinary tract infections by implementing the Comprehensive Unit-Based Safety Program (CUSP); *Clostridium diffcile,* and surgical site infections. Hospitals that participate in QIO initiatives can expect to receive

Continued

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technical assistance for reporting HAI data, as well as opportunities for peer-to-peer learning through the statewide LAN, access to and training on evidence-based tools like the central line checklist, support for rapid-cycle improvement, and strategies for spreading success within their hospital.

Health Care-Acquired Conditions in Nursing Homes

Nursing homes that join KFMC's health care-acquired conditions (HAC) initiatives will contribute to a 40 percent national reduction in HAC rates. Work to reduce HACs begins with technical assistance to improve pressure ulcer prevention and reduce physical restraint use, building on the success of nursing homes that participated in recent KFMC initiatives on these topics. Facilities can expect to receive on-site consultation by KFMC, training in quality improvement skills, evidence-based tools and resources and ongoing education. Beginning in 2013, KFMC will launch a statewide LAN for nursing homes that will work to reduce inappropriate antipsychotic use and other HACs. LAN participants can learn from local and national peers, obtain evidence-based tools and resources and participate in improvement collaboratives.

Adverse Drug Events in the Community

Outpatient providers who join KFMC's adverse drug event (ADE) initiative will be contributing to a national goal of reducing ADEs in 265,000 lives per year. KFMC is bringing together clinical pharmacists, primary care clinics and other providers to provide education and clinical monitoring to beneficiaries who are at high risk for adverse drug events. The initiative is modeled on the Health Resources and Services Administration's successful Patient Safety and Clinical Pharmacy Services (PSPC) Collaborative. Participants can expect to benefit from participation in a statewide LAN, access to evidence-based tools for assessing pharmacy processes and implementing safer practices, support for rapid-cycle improvement, and strategies for spreading success within their community.

Accurate Data about Hospital Quality

Good data means more transparency about the state of quality and safety at America's hospitals. The clinical data KFMC guides hospitals in collecting are the same data CMS uses to populate the Hospital Compare website, which is designed to help consumers choose where to receive care. They also are the same data CMS will use to calculate hospitals' value-based payment rates. Just as they have in the past, KFMC will offer technical assistance to all Medicare participating hospitals for reporting inpatient and outpatient quality data to CMS. This includes help with the reporting tool, updates on measure definitions and reporting procedures and responsiveness to facility-specific issues and questions.

Learn more and become involved

KFMC invites all providers, community stakeholders, beneficiaries, family members and caregivers to become partners in its new improvement initiatives. More information about KFMC's Integrating Care for Populations and Communities initiative is available online at *kfmc.org*. To express an interest, contact KFMC or visit *kfmc.org*.

This material was prepared by the Kansas Foundation for Medical Care, Inc. (KFMC), the Medicare Quality Improvement Organization for Kansas, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 10SOW-KS-CRISP_13_04

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NEWS RELEASE

FOR IMMEDIATE RELEASE

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January 23, 2013

JAMA article confirms local approach to reducing hospital readmissions

Kansas Foundation for Medical Care leads four communities across Kansas in improving care transitions

Topeka, Kan. – When Medicare patients make an unplanned return to the hospital that could have been avoided by better care coordination, it delays their recovery, unnecessarily exposes them to such hospital dangers as infection, costs taxpayers money and consumes increasingly scarce health care resources. In Kansas, the approach that four communities are taking to improve the transition between hospital and post-hospital care now has been validated by research that will appear in the January 23, 2013, edition of JAMA, the Journal of the American Medical Association.

The JAMA article describes a project in communities in 14 states that produced an average 6% decrease in hospitalizations and re-hospitalizations over two years, at nearly twice the pace in participating communities as in comparison sites. Conducted between 2008 and 2011, the project was performed by Medicare Quality Improvement Organizations with funding from the Centers for Medicare & Medicaid Services (CMS), the Federal agency that administers Medicare. This project formed the foundation for work currently being spearheaded in Kansas by the Kansas Foundation for Medical Care (KFMC).

"Our data show that nearly one in five patients who leave the hospital today will be re-admitted within the next month, and that more than three-quarters of these re-admissions are potentially preventable," said Dr. Patrick Conway, CMS Chief Medical Officer and Center for Clinical Standards & Quality Director. "This situation can be changed by approaching health care quality from a community-wide perspective, and focusing on how everyone who touches a patient's life—whether part of the traditional 'health care team' or not—can better work together in the best interests of their shared patient population to prevent hospitalizations."

In 2011, the Kansas 30-day all cause hospital readmission rate, per 1,000 Medicare fee-for-service beneficiaries, was 49.4 compared to the national rate of 56.8. KFMC is working statewide and with four coalitions in Hays, Kansas City, Topeka and Wichita to further reduce the Kansas rate.

Following the model described in the JAMA study, these coalitions bring together not only hospitals, but also nursing homes, home health care agencies, hospices, dialysis facilities and social service agencies such as Area Agencies on Aging.

KFMC coaches and educates local coalitions on:

- Discovering the reasons behind the community's readmissions rates;
- Applying medical research findings in ways that reduce readmissions, such as methods for educating patients about caring for themselves when they return home, ways that health care facilities and providers can better communicate as patients move among them, and fixing complex discharge plans to give the patient what he/she needs to stay healthy outside of the hospital;
- Tailoring best practices in reducing readmissions to the specific needs of the community; and
- Analyzing data to gauge progress and impact.

In addition, KFMC connects coalition participants to other organizations in the state and nation to share best practices and lessons learned for helping patients transition out of hospital care and serves as an informational resource for any community in Kansas that wants to reduce avoidable hospital readmissions.

"The health care system is multifaceted and can be challenging to seniors with chronic conditions who rely on many providers and services for their care," said Kenneth Mishler, KFMC President and CEO. "We are excited to be part of the Care Transitions initiative in Kansas to break down barriers in the care delivery system and encourage collaboration between all providers to offer the care that is in the best interest of the patients."

The efforts that KFMC is undertaking are part of a national project that is transforming health care in more than 400 communities across the country. Called "Integrating Care for Populations and Communities," the project is part of the Medicare Quality Improvement Organization Program. More details can be found at *kfmc.org*.

About Kansas Foundation for Medical Care

The Kansas Foundation for Medical Care (KFMC) is the Quality Improvement Organization (QIO), the Regional Extension Center (REC) and External Quality Review Organization (EQRO) for the state of Kansas. KFMC also contracts with many private companies to provide health information technology (HIT) consulting services, quality improvement and review services. Throughout various contracts, our

role is to work with healthcare providers and organizations to develop ways to improve the use of HIT and the quality of healthcare provided to all Kansas healthcare consumers.

About the QIO Program

The QIO Program is a major force and trustworthy partner for the continual improvement of health and health care for all Americans. The program achieves national health quality goals through a network of 53 QIOs located in every state, territory and the District of Columbia. QIOs bring together patients, providers, practitioners and other stakeholders to improve patient care, improve population and community health, and lower the costs of care through improvement.

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Association Between Quality Improvement for Care Transitions in Communities and Rehospitalizations Among Medicare Beneficiaries

Jane Brock, MD, MSPH; Jason Mitchell, MS; Kimberly Irby, MPH; Beth Stevens, MS; Traci Archibald, OTR/L, MBA; Alicia Goroski, MPH; Joanne Lynn, MD, MA, MS; for the Care Transitions Project Team

JAMA. 2013;309(4):381-391.

Abstract

Importance Medicare beneficiaries experience errors during transitions among care settings, yielding harms that include unnecessary rehospitalizations.

Objective To evaluate whether implementation of improved care transitions for patients with Medicare fee-for-service (FFS) insurance is associated with reduced rehospitalizations and hospitalizations in geographic communities.

Design, Setting, and Participants Quality improvement initiative for care transitions by health care and social services personnel and Medicare Quality Improvement Organization staff in defined geographic areas, with monitoring by community-specific and aggregate control charts and evaluation with pre-post comparison of performance differences for 14 intervention communities and 50 comparison communities from before (2006-2008) and during (2009-2010) implementation. Intervention communities had between 22 070 and 90 843 Medicare FFS beneficiaries.

Intervention Quality Improvement Organizations facilitated community-wide quality improvement activities to implement evidence-based improvements in care transitions by community organizing, technical assistance, and monitoring of participation, implementation, effectiveness, and adverse effects.

Main Outcome Measures The primary outcome measure was all-cause 30-day rehospitalizations per 1000 Medicare FFS beneficiaries; secondary outcome measures were all-cause hospitalizations per 1000 Medicare FFS beneficiaries and all-cause 30-day rehospitalizations as a percentage of hospital discharges.

Results The mean rate of 30-day all-cause rehospitalizations per 1000 beneficiaries per quarter was 15.21 in 2006-2008 and 14.34 in 2009-2010 in the 14 intervention communities and was 15.03 in 2006-2008 and 14.72 in 2009-2010 in the 50 comparison communities, with the pre-post between-group difference showing larger reductions in rehospitalizations in intervention communities (by 0.56/1000 per quarter; 95% CI, 0.05-1.07; $P = .03$). The mean rate of hospitalizations per 1000 beneficiaries per quarter was 82.27 in 2006-2008 and 77.54 in 2009-2010 in intervention communities and was 82.09 in 2006-2008 and 79.48 in 2009-2010 in comparison communities, with the pre-post between-group difference showing larger reductions in hospitalizations in intervention communities (by 2.12/1000 per quarter; 95% CI, 0.47-3.77; $P = .01$). Mean community-wide rates of rehospitalizations as a percentage of hospital discharges in the intervention communities were 18.97% in 2006-2008 and 18.91% in 2009-2010 and were 18.76% in 2006-2008 and 18.91% in 2009-2010 in the comparison communities, with no significant difference in the pre-post between-group differences (0.22%; 95% CI, −0.08% to 0.51%; $P = .14$). Process control charts signaled onset of improvement coincident with initiating intervention.

Conclusions and Relevance Among Medicare beneficiaries in intervention communities, compared with those in uninvolved communities, all-cause 30-day rehospitalization and all-cause hospitalization declined. However, there was no change in the rate of all-cause 30-day rehospitalizations as a percentage of hospital discharges.

Kansas Foundation for Medical Care, Inc.

External Quality Review Organization

Description of Services

Kansas Foundation for Medical Care (KFMC) has provided external quality review services since the state of Kansas' initial implementation of Medicaid Managed Care in 1995. Most recently the EQRO contract has been with the Kansas Department of Health and Environment (KDHE), Division of Health Care Finance.

KFMC has experience implementing the following CMS EQR Protocols:

- Monitoring Managed Care Organizations' (MCO) compliance with Medicaid Managed Care Regulations.
- Validating Performance Measures
- Validating Performance Improvement Projects
- Information Systems Capabilities Assessment
- Administering or Validating Surveys
- Conducting Performance Improvement Projects
- Conducting Focused Studies of Healthcare Quality
- Validating Encounter Data
- Calculating Performance Measures

Other related review activities completed by KFMC:

- Monitored Access to Care (geographical mapping and timeliness of care)
- Conducted consumer and provider surveys
- Reviewed MCO grievances/appeals and disenrollments
- Conducted quality improvement projects and studies regarding; lead screening, childhood immunizations, C-Section rates, Early Periodic Screenings, Diagnosis and Treatment (EPSDT) and gastroenteritis

Kansas Department for Aging and Disability Services (KDADS) Mental Health and Addiction and Prevention Services-EQRO services since October 2007

- In addition to many of the above Protocol activities, KFMC work has included review of Home and Community Based Services (HCBS) waivers and conducting an annual mental health consumer satisfaction survey to assist in National Outcomes Measures reporting. KFMC has provided Technical Assistance regarding Waiver performance measurement.

Kansas Department for Children and Families-EQRO services October 2003-2005

- Reviewed case records from foster care and adoption contractors for medical necessity, quality of care, documentation and billing as well as conducted validation of encounter data.

KDHE-Kansas Immunization Program-EQRO services since 2011

- Project management
- Surveys

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Kansas Foundation for Medical Care, Inc.

Utilization Review Services

Description of Services

KFMC has been responsible for peer review of Medicare admissions since 1977 and has received recognition for achievement as a Quality Improvement Organization (QIO) from the Centers for Medicare & Medicaid Services (CMS). Peer review uses a network of physicians to educate and increase consistency among providers as it relates to quality of care in the appropriate setting. KFMC has gained significant experience with the Medicaid program and has worked with the state of Kansas since 1982. KFMC is currently responsible for reviewing admissions under this program.

KFMC reviews inpatient non-managed care claims of Medicaid beneficiaries to make sure they were provided appropriate care in the appropriate setting. Our primary functions include the operation of a review system to monitor the quality, diagnosis and procedure validation, medical necessity, discharge appropriateness and appropriateness of health care provided to Medicaid consumers. Provider education is a component of this work. KFMC uses Milliman Care Guidelines, state contract directives and Agency for Healthcare Research and Quality (AHRQ) quality indicators to provide analysis of medical care provided to Kansas Medicaid beneficiaries.

KFMC non-physician reviewers apply Milliman Care Guidelines for medical necessity and appropriateness of care. These guidelines are tools used by the non-physician reviewers to identify potential issue(s) in the care provided to patients. When potential issue(s) are identified the case is sent to a physician of the same specialty and similar setting. KFMC has a well-developed network of physician reviewers across the state of Kansas. KFMC also uses Care Web QI and AHRQ quality indicators as a part of this work. Care Web QI is a web-based software extension of the Milliman Care Guidelines that uses the concept that variation from the expected course of recovery can signal opportunities for improvement in care. AHRQ indicators are based on claims analysis and are intended to provide information that can draw attention to high- or low-performing hospitals in several clinical areas.

In addition, KFMC reviews complaints and/or grievances as identified by the fiscal agent as well as special referrals. KFMC serves as a knowledgeable resource to the State in matters of utilization review and external quality review.

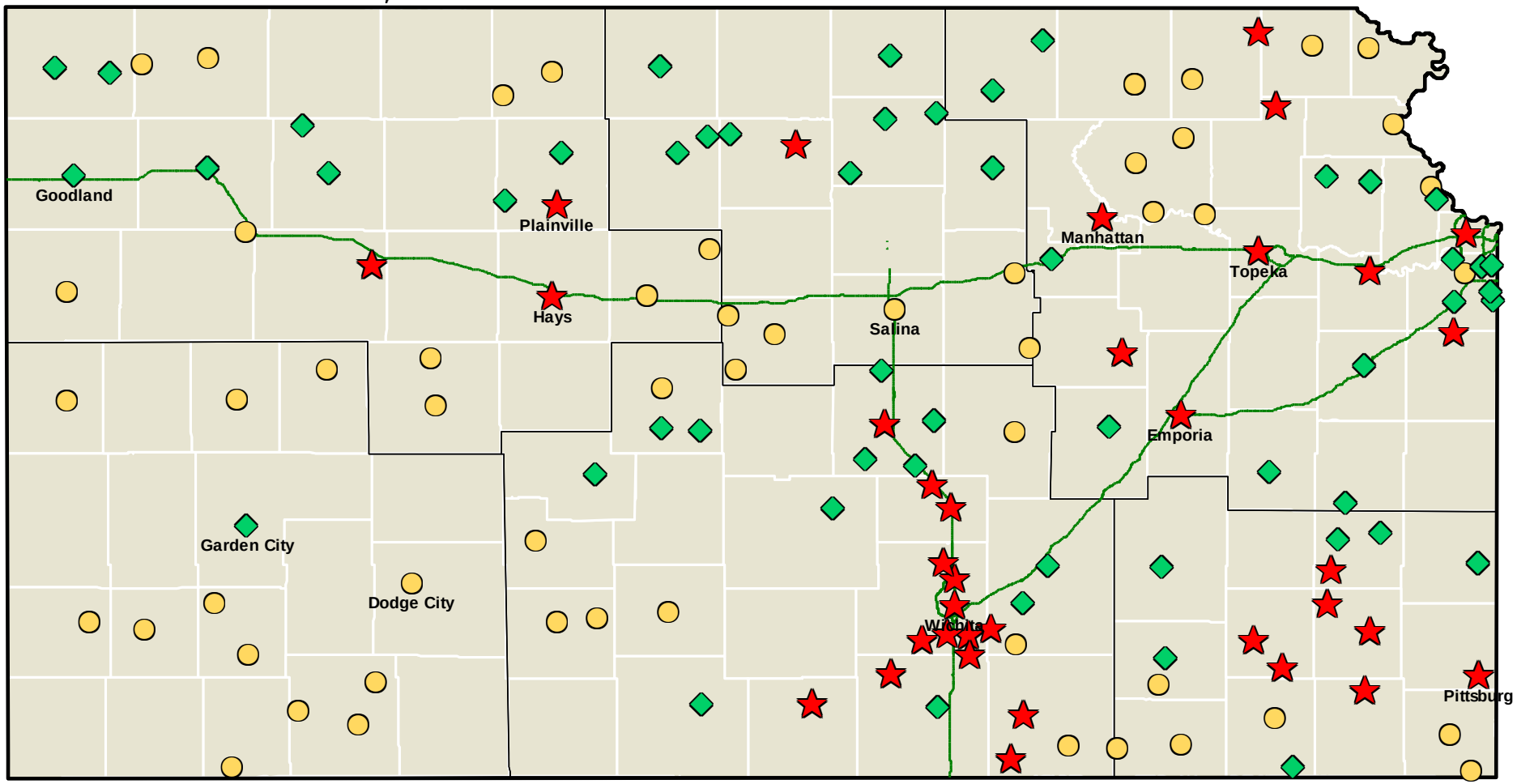
<u>Private Reviews</u>
KFMC has 35 years of valuable experience providing peer reviews services in many areas of the medical profession to private sector clients.

KFMC's Physician Reviewer Program provides physician sponsored, objective peer review and opportunities for related education. The program is tailored to the client's needs and provides other services that contribute to increasing quality medical care and appropriate use of medical services.

<u>Kansas Insurance Department</u>
KFMC is the external review organization that conducts independent external reviews of adverse decisions and renders decisions in accordance with State Statutes and Regulations for the Kansas Insurance Department. These reviews consist of Standard and Expedited Review Procedures.

Kansas Foundation for Medical Care, Inc.

Regional Extension Center Participants



as of Jan 28, 2013

- 1574 Practitioners (1200 PPCPs and 374 non-PPCPs are signed up)
- 1107 Practitioners (985 PPCPs and 122 non-PPCPs are e-prescribing and generating quality reports)
- 472 Practitioners (437 PPCPs and 35 non-PPCPs) at Meaningful Use

This material was prepared by Kansas Foundation for Medical Care, Inc. as part of our work as the Kansas Regional Extension Center, under grant #90RC0003/01 from the Office of the National Coordinator, Department of Health & Human Services.

Accelerating aHIT
Health Information Technology in Kansas

Kansas Foundation for Medical Care, Inc.

Your Trusted Source

The Kansas Foundation for Medical Care (KFMC) is your trusted partner in healthcare consulting. For more than 40 years, KFMC has been facilitating the improvement of healthcare in Kansas. KFMC is the organization health-care providers, consumers and local governments alike turn to in order to ensure Kansans are receiving the best possible care.

Where Experience Matters

KFMC's diverse team knows the ins and outs of healthcare and its ever-changing environment. Our team is comprised of professionals who are currently or have worked in the field, including physicians, nurses, pharmacists, quality improvement professionals, social workers, data analysts, communications experts and health information technology specialists. KFMC is equipped to go to work for you.

Healthcare Business Services and Solutions

Quality Improvement
Patient Safety Strategies
Education & Training

Health Information Technology
External Quality Review
Change Management
Data & Analysis
Facilitation

Program & Project Management
Medical Review
Survey Development

Quality Improvement

KFMC is the state's leader in quality improvement. Our team's knowledge and experience is unsurpassed in multiple healthcare delivery settings, from urban to rural hospitals to nursing homes and physician clinics. KFMC's Quality Improvement team has expertise in clinical and organizational quality improvement methodology, tools and techniques, performance measurement and analysis, data display and change management. KFMC specializes consulting on patient safety with recent projects including reduction of surgical complications, healthcare associated infections, pressure ulcers, and physical restraints.

KFMC currently holds multiple contracts at the provider, state and federal levels utilizing these services to enhance the quality of care for those we serve. KFMC has been the federally designated state Quality Improvement Organization for the past 38 years.

Data & Analysis

KFMC has many years of comprehensive analytic experience, helping contractors gather and analyze healthcare information. KFMC's team knows how to gather data through medical record abstraction, surveys, focus groups, by interfacing with multiple administrative data centers, as well as in development of outcome/performance measures, data system analysis and encouter data validation. KFMC has the capability to conduct analyses on robust data sets including Medicare and Medicaid claims data. Not only can we access and record data, we present data in meaningful, useful reports that center around service, outcomes and client satisfaction.

KFMC has held multiple contracts with government and private entities to assist with data analysis and survey development and analysis.

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Health Information Technology

As healthcare providers across the nation implement Electronic Health Record (EHR) systems, KFMC is prepared to assist providers in every aspect of Health Information Technology (HIT). Our team of trained HIT professionals are advocates for healthcare providers, helping take your organization from its current state, whether you are starting with a paper-based system or just need to optimize your current EHR, to Meaningful Use in order to qualify for Medicare or Medicaid incentives. KFMC's team provides asssitance with provider education and outreach, vendor selection and group purchasing, project management, implementation, practice and workflow redesign, functional interoperability and Health Information Exchange, privacy and security best practices, and progress toward Meaningful Use.

KFMC is the federally designated HIT Regional Extension Center (HITREC) for the state of Kansas.

External Quality Review

KFMC's External Quality Review (EQR) activities focus on healthcare access, quality and timeliness. The EQR team is knowledgeable and experienced in using the CMS protocols to monitor and evaluate Managed Care Organization and Pre-Paid In-Patient Health Plan activities. The EQR team also has experience in conducting surveys, medical reviews, utilization review, calculating performance measures and completing focused studies that meet the CMS EQR protocol requirements. We strive to meet and exceed the CMS requirements for all EQR activities and reviews, and work with state Medicaid agencies and their stakeholders to provide actionable recommendations geared toward improvement of access, quality and timeliness of care for their consumers.

KFMC has held the Utilization Review contract since 1982 and the External Quality Review Organization contract since 1995.

Education & Training

The Continuing Professional Education (CPE) Program of KFMC is based in collaboration and partnership with the Kansas physician and nursing community and is grounded in scientific data, knowledge and care standards. Our goal is to improve the quality and effectiveness of healthcare through CPE by providing quality improvement data and strategies, new knowledge, skills and techniques. Our team strives to foster a climate that promotes open communication, learning, professional growth and collaboration. We are skilled in planning and implementing meetings, seminars, webinars and self-directed study programs.

KFMC has provided conferences, training and education programs for physicians, nurses, and other healthcare staff for over 15 years.

Let Us Help You Develop Healthcare Business Solutions

As Kansas' premier healthcare improvement organization for more than 40 years, KFMC has a strong record of performance and outcomes with its many clients and contracts. We are dedicated to providing educated, trained healthcare business professionals who are passionate, responsive, flexible and make your needs a priority. Call KFMC today to learn how we can become your partner and work together to improve the quality of healthcare.

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Mission

Leading innovation to improve the quality, effectiveness and safety of healthcare.

Vision

KFMC will be a leader, trusted partner and catalyst for transformational improvement in healthcare. Through our innovative idea, extensive experience, diverse skills, high quality services and intentional collaboration, we will improve the health of people and communities.

Values

We hire great people who in pursuit of KFMC's Mission and Vision commit to these core values to guide our decisions and behaviors.

Integrity
Conducting business in an honest and ethical manner and being accountable for our decisions and actions.

Excellence
Continually building skills and knowledge to be experts in our work and using these to produce the highest quality work product every time.

Innovation
Inventing the future, learning from our failures, thus achieving greater value from resources.

Collaboration
Working together inclusively and respectful.

Wellness
Creating an environment that promotes optimal physical, mental and social health.